HNE
HEALTH NEW ENGLAND
One Monarch Place • Suite 1500
Springfield, MA 01144-1500
Phone 413-787-4000 • 800-842-4464 • Enrollment Fax - 413-233-2635
hnewhizkidz.com • hne.com

ENROLLMENT/ADD/TERMINATION FORM

PLEASE COMPLETE ALL INFORMATION

PLEASE PRINT

EMPLOYEE NAME (FIRST, MIDDLE, LAST)	GROUP/COMPANY NAME	OPTION
	Town of Longmeadow	
PCP FIRST & LAST NAME *(does not apply to PPO)*	PCP PROVIDER ID# *(found in the provider directory)*	IS THIS YOUR DOCTOR NOW? ❑ YES ❑ NO

SS#	DOB MONTH DAY YEAR	GENDER
- -	- -	❑ MALE ❑ FEMALE

ADDRESS APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )

TELEPHONE (WORK) ( )

MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ OTHER

HAVE YOU EVER BEEN A MEMBER OF HEALTH NEW ENGLAND? ❑ YES ❑ NO

IF YES, PLEASE LIST FORMER NAME (if applicable) _____

AND FORMER IDENTIFICATION NUMBER _____

WILL YOU OR ANY MEMBER OF YOUR FAMILY BE COVERED THROUGH ANOTHER HEALTH INSURANCE? ❑ YES ❑ NO

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____ POLICY # _____

NAME OF INSURANCE CO. _____ EFFECTIVE DATE: _____

NAMES OF COVERED INDIVIDUALS _____

IS EMPLOYEE RETIRED? ❑ YES (provide copy of Medicare card) ❑ NO

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE? ❑ YES ❑ NO

IF YES, ❑ PART A ❑ PART B ❑ BOTH *IF YES, A COPY OF YOUR MEDICARE CARD(S) MUST BE ATTACHED.*

DO YOU CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT AND COMPLETE? ❑ ***YES*** ❑ ***NO***

EACH MEMBER MUST SELECT A PRIMARY CARE PHYSICIAN. IF A PCP IS NOT CHOSEN, HNE WILL ASSIGN A DOCTOR FOR YOU (DOES NOT APPLY TO PPO).

PLEASE PRINT

DEPENDENT NAME(S) FIRST MIDDLE LAST *(if not same as employee)*	DATE OF BIRTH MO DAY YR	SEX		SOCIAL SECURITY NUMBER	PCP LAST	FIRST	PROVIDER ID#	IS THIS YOUR DOCTOR NOW?	
❑ *Spouse* ❑ *Other*	- -	M	F	- -				Y	N
Dependent	- -	M	F	- -				Y	N
Dependent	- -	M	F	- -				Y	N
Dependent	- -	M	F	- -				Y	N
Dependent	- -	M	F	- -				Y	N

FOR DEPENDENT(S) AGED 21-26, I ATTEST TO THE FOLLOWING: (DEPENDENT ELIGIBILITY RULES MAY VARY FOR SELF-FUNDED PLANS.)

DEPENDENT NAME(S)	HE/SHE IS A FULL-TIME STUDENT?	I WILL CLAIM HIM/HER AS A DEPENDENT FOR IRS TAX PURPOSES IN THE CURRENT CALENDAR YEAR.	IF NO, THE LAST YEAR I CLAIMED HIM/HER AS A DEPENDENT FOR IRS TAX PURPOSES WAS IN CALENDAR YEAR:
	❑ YES ❑ NO	❑ YES ❑ NO	
	❑ YES ❑ NO	❑ YES ❑ NO	

I UNDERSTAND THAT BY ACCEPTING COVERAGE UNDER THIS PLAN, HNE AND ANY HEALTH CARE PROVIDER MAY RECEIVE, USE AND DISCLOSE MY MEDICAL INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND ANY AND ALL OTHER USES ALLOWED BY LAW. I HAVE READ AND UNDERSTAND THE TERMS OF ENROLLMENT ON THE BACK OF THIS FORM. I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

(X) _____

EMPLOYEE SIGNATURE **DATE**

TO BE COMPLETED BY EMPLOYER

❑ NEW ENROLLMENT EFF. DATE _____

REASON

- ❑ NEW HIRE
- ❑ PART-TIME TO FULL-TIME
- ❑ ANNUAL OPEN ENROLLMENT
- ❑ OTHER _____
- ❑ LOSS OF INSURANCE (must attach documents)
- ❑ MOVED INTO SERVICE AREA

❑ CHANGE TO CURRENT POLICY EFF. DATE _____

REASON

- ❑ CHANGE COVERAGE TYPE
- ❑ ADD DEPENDENT LISTED ABOVE
- ❑ TERMINATE DEPENDENT LISTED ABOVE
- ❑ TRANSFER TO COBRA
- ❑ NAME/ADDRESS CHANGE
- ❑ LOSS OF INSURANCE (must attach documents)
- ❑ MARRIAGE
- ❑ OTHER _____

❑ TERMINATION OF POLICY END DATE _____

REASON

- ❑ LEFT EMPLOYMENT
- ❑ VOLUNTARY CANCELLATION
- ❑ MOVED FROM SERVICE AREA
- ❑ NO LONGER ELIGIBLE
- ❑ DECEASED

TYPE OF PLAN: ☒ **HMO** ❑ **Advantage Plus (POS)** ❑ **PPO** **TYPE OF COVERAGE:** ❑ **INDIVIDUAL** ❑ **FAMILY** ❑ **OTHER**

DATE OF HIRE: _____ **HNE GROUP #:** S 0 3 0 4 2 — 0 0 0 _ **EMPLOYER SIGNATURE:** _____ **DATE:** _____

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IMPORTANT: PLEASE READ THESE TERMS OF ENROLLMENT

As an employee I understand that:

1. By submitting this form or accepting coverage under the plan, I agree, on behalf of myself and all enrolled dependents, to abide by the terms of the HNE Agreement, which includes this form as well as the applicable Explanation of Coverage or Summary Plan Description.

2. Membership will become effective upon acceptance by the Plan and that benefits under the Plan will be explained in a separate document (Explanation of Coverage or Summary Plan Description).

3. I may only enroll dependents subject to the guidelines outlined in my HNE Agreement.

4. Whenever I seek treatment or services, I must identify myself as a Health New England member by presenting my Health New England Identification Card.

5. I must select a Primary Care Physician for myself and my dependents (does not apply to PPO).

6. If appropriate, I authorize my employer to deduct from my wages the rate required for the coverage selected.

As an employer I understand that:

1. By submitting this form, I certify that the information provided on this form is accurate.